SIR,—I am reluctant to trespass on your tolerance so soon after my letter (6 September, p. 592), but your leading articles on "Society's Rejects" and "Exploitation of Nurses" (8 November, pp. 317, 320) so clearly relate to what I then wrote that I feel I must comment further on what is becoming a major two-pronged threat to our psychiatric hospital services—the financial exploitation of, and the destruction of morale among, our nursing colleagues.

On the first count your leading article said all that I would and more; I can only underline your last sentence "they have every right to expect that their medical colleagues . . . will help them achieve economic justice."

On the second count, may I draw attention to one aspect of allegations of ill usage made against members of the nursing staff which by its very nature cannot be known to the general public? There is a high incidence of complaints which, on exhaustive and critical inquiry (often resulting in considerable distress to totally innocent nurses), turn out to be without any foundation—and which, on occasion, seem to be projections of the complainant's own guilts in relation to the patient. The situation which then arises, that the rare complaint which is well-founded rightly receives considerable publicity while the many which are not receive none, is well calculated to wear away the morale of any human being who is not totally insensitive. And, with the exception of the black sheep to be found in any group of people, psychiatric nurses are not insensitive; they are skilled and loyal and humane members of a hospital team, their membership of which is most certainly not motivated by financial gain.

That they work among society's rejects, and often under adverse environmental conditions (especially in the subnormality field), is something society takes for granted and without comment. Perhaps knowledge of human nature in general should lead one to expect this and even to accept it; but I feel I must reiterate my contention that we, the medical profession, should neither expect nor accept it, nor are we in any position to do so. Out of loyalty to our nursing colleagues we ought to be more vociferous in our support of them; out of necessity to our continued function in hospital we must be. To put it at its very lowest, enlightened self-interest obliges us to come strongly and actively to their defence: we cannot function without them.—I am, etc.,

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*** Some details of the nurses' pay claim are given at p. 506.—ED., *B.M.J.*

SIR,—I was delighted to read your leading article (8 November, p. 320) taking up the cudgels on behalf of the nursing profession, and commenting so aptly on the anomalies which exist in the pay scale for nurses.

I must point out, however, that an even more devastating *non sequitur* is condoned by the medical politicians. I refer to the non-payment of a small, but I beg to suggest valuable, number of S.R.N.s, whose husbands are general practitioners, and who work as trained personnel in their husband's practice. On the claim form ANC.1, para 10, it is necessary to specify the relationship of the employee to a member of the practice. This, I believe, assumes that although I work for my husband's practice for a minimum of five hours per week, and a maximum of goodness knows what—not on what have been described as "normal wifely duties"—the practice cannot claim, whereas if I worked for another practice, or divorced my husband and continued to work for his practice, three-fifths of my salary would be paid by the executive council.

This state of affairs involves only a small number of nurses, but I know from articles published in journals that others find themselves in the same predicament as myself. I presume that this anomaly persists because the powers that be assume that general practitioners still have their surgeries attached to their houses, and assume that nurses can maintain that they are running, for example, an antenatal clinic, or setting up an age–sex register, when in fact they are doing the family washing. Try doing that from a distance of half a mile.—I am, etc.,

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Incidence of Trachoma

SIR,—I must compliment Dr. C. H. L. Howells and others on their excellent paper calling attention to the changing pattern in trachoma (18 October, p. 127).

In case this should be thought to be a purely West Midlands problem, I should point out that we are seeing fresh cases of acute follicular trachoma in the Medway Towns area. With two exceptions, these have been entirely from the Sikh population, and I would echo the findings of the West Midlands survey that a high percentage of the Punjabis are in fact showing signs of trachoma, however slight. In fact in my clinics I have for some time had a ruling that all Punjabis have trachoma until proved otherwise.

In view of this relatively recent upsurge of trachoma in our clinics I think it is most important that the extent of the problem should be fully realized, and I would add to the plea that acute follicular trachoma should be a notifiable disease.—I am, etc.,

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SIR,—I would like to make a few comments about the paper on trachoma by Dr. C. H. L. Howells and others (18 October, p. 127). The authors say ". . . during the whole of recorded history it [trachoma] has remained prevalent in the Near and Middle East." The unsuspecting would be led to believe that the rest of the world is free from it. However, it does occur in South America, the United States, and in Spain—not to mention many other countries.

They speak of "infected carriers." I presume they mean "patients." I am not aware of the existence of healthy carriers of trachoma.

They quote Cook for the statement that "It was brought into Europe by the armies after Napoleon's Egyptian campaign, and Moorfields Eye Hospital in London was founded to deal with the Egyptian ophthalmia."[1] It is rather odd that the Moors, who ruled much of South Europe a few centuries before Napoleon was conceived, failed to take trachoma to Europe. I am sure our pre-Cook medical historians have been bending history a wee bit. Anyway, why didn't Caesar and Antony borrow a bit of the virus from Cleopatra?

If trachoma did arrive in Britain—either with Robert Clive and Warren Hastings, or with the Duke—and if it did die out without the help of the sulphas and the antibiotics, it did so in spite of the overcrowded slums and the lack of baths (and I dare say towels as well) which characterized the great cities of this country during the last century. I believe the authors are being unduly alarmist when they make the extravagant plea for special clinics to be established. "Eradication of trachoma from a community, as with tuberculosis, will depend on laboratory methods," they say. Quite wrong. The authors will recall that the Egyptian ophthalmia faded out without "laboratory methods."

Surma is not an "eyelash blackener." The Punjabi's eyelashes are black anyway, as no doubt the clinicians among the authors observed when they examined their patients. The *salai* is smooth and blunt, and I doubt the claim that it produces conjunctival abrasions. Nobody doubts, however, that the *salai* is the instrument of cross-infection, and this has been the teaching in the medical schools in the Punjab for many years.—I am, etc.,

J. K. ANAND.

London E.7.

REFERENCE

1 Cook, C., *British Journal of Ophthalmology*, 1961, **45**, 241.

Disposable Artificial Kidney

SIR,—There is one facet of the interesting article by Mr. A. E. Kulatilake and others (23 August, p. 447) on the Swedish disposable artificial kidney which worries us considerably. We note that with both the disposable and the Kiil dialyser the mean blood flow throughout dialysis in the 12 patients who were used in the trial was about 100 ml./min. No comment is made about this. We also note that the patients were only dialysed for 12 hours twice a week.

It is our opinion that patients on maintenance haemodialysis on a two-layered Kiil dialyser should be dialysed for at least 14 hours twice a week or 9–10 hours three times a week. And it is our practice to increase this to 30–32 hours in patients who weigh more than 70–75 kg. In addition, we electively recannulate if the blood flow on dialysis is consistently below 120 ml./min. Our average blood flows are around 170 ml./min. for patients with Scribner shunts. One of us also has many patients with arteriovenous fistulae; in these the average flows are 200 ml./min.

In our experience, when we used to dialyse patients for only 12 hours twice a week they were under-dialysed, even if the blood flows were far greater than 100 ml./min. They suffered from an unnecessarily high incidence of those complications which are usually associated with untreated advanced chronic renal failure, including bone disease,